STUDENT'S NAME:____________________________ STUDENT ID #:___________________________________
(Please print last name first)

ROSS S. STERLING HIGH SCHOOL BAND
CONSENT FOR MEDICAL TREATMENT

TO WHOM IT MAY CONCERN:

I, the undersigned, being the parent, legal next of kin, or the legal guardian of:

____ ______________________________
Name of student **Date of birth**

Hereby grant authorization to the Director(s) of Ross S. Sterling High School Band, or employee(s) of Goose Creek Consolidated Independent School District, to obtain any emergency medical and/or surgical treatment and procedures from a physician or hospital emergency room physician on behalf of the above named minor.

____ ______________________________
Signature of person giving consent **Date** **Relationship to student**

____ ______________________________
Type or print name **Witnessed by**

GENERAL INFORMATION (PLEASE PRINT)

STUDENT NAME:_________________________________ **HOME TELEPHONE:** __________________________

ADDRESS:____ **CELL PHONE:** __________________________________

CITY/STATE/ZIP:____

RESPONSIBLE PERSON:_________________________ **HOME TELEPHONE:** __________________________

ADDRESS:____ **CELL PHONE:**__________________________________

CITY/STATE/ZIP:________________________________ **WORK PHONE:** ________________________________

LOCAL RELATIVE/NEIGHBOR:_________________________ **HOME TELEPHONE:** ____________________

ADDRESS:____ **CELL PHONE:** ________________________

CITY/STATE/ZIP:____ **WORK PHONE:**__________________

Allergies:____
____